FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024745

Facility Name: WINNING WHEELS

Address: 701 E. THIRD STREET (Number) PROPHETSTOWN (City) 61277 (Zip Code)

County: WHITESIDE

Telephone Number: 815-537-5168 **Fax #** 815-537-5268

IDPA ID Number: 237136038001

Date of Initial License for Current Owners: 01/01/79

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ALAN GAPINSKI **Telephone Number:** 815-778-3683

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ALAN GAPINSKI
(Title) CEO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,665	1,556	870	6,091	8
9	SNF/PED					9
10	ICF	21,838		73	21,911	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,503	1,556	943	28,002	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.90%

D. How many bed-hold days during this year were paid by Public Aid? 800 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/79

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 870

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	165,562	21,161	890	187,613	2,389	190,002		190,002			1
2	Food Purchase		161,185		161,185		161,185	(1,840)	159,345			2
3	Housekeeping	56,044	19,732		75,776		75,776		75,776			3
4	Laundry	57,950	19,602		77,552	531	78,083	(21,000)	57,083			4
5	Heat and Other Utilities			75,472	75,472		75,472	(5,365)	70,107			5
6	Maintenance	72,592	50,337	53,040	175,969		175,969		175,969			6
7	Other (specify):*											7
8	**TOTAL General Services**	352,148	272,017	129,402	753,567	2,920	756,487	(28,205)	728,282			8
	B. Health Care and Programs											
9	Medical Director			23,625	23,625		23,625		23,625			9
10	Nursing and Medical Records	979,616	181,721	3,558	1,164,895	(21,468)	1,143,427		1,143,427			10
10a	Therapy	72,554		73,652	146,206		146,206		146,206			10a
11	Activities	68,243	13,653	1,920	83,816		83,816		83,816			11
12	Social Services	73,834			73,834		73,834		73,834			12
13	Nurse Aide Training					31,129	31,129	(18,547)	12,582			13
14	Program Transportation	12,794	12,992		25,786	(16,853)	8,933		8,933			14
15	Other (specify):*	31,950	168	25,419	57,537		57,537		57,537			15
16	**TOTAL Health Care and Programs**	1,238,991	208,534	128,174	1,575,699	(7,192)	1,568,507	(18,547)	1,549,960			16
	C. General Administration											
17	Administrative			153,500	153,500		153,500	(32,059)	121,441			17
18	Directors Fees											18
19	Professional Services			18,529	18,529		18,529	1,462	19,991			19
20	Dues, Fees, Subscriptions & Promotions			28,396	28,396		28,396	417	28,813			20
21	Clerical & General Office Expenses	161,208	22,296	68,532	252,036		252,036	1,174	253,210			21
22	Employee Benefits & Payroll Taxes			304,965	304,965	(7,035)	297,930	23,901	321,831			22
23	Inservice Training & Education			12,765	12,765	(5,546)	7,219		7,219			23
24	Travel and Seminar			22,445	22,445		22,445	(273)	22,172			24
25	Other Admin. Staff Transportation							1,087	1,087			25
26	Insurance-Prop.Liab.Malpractice			24,381	24,381		24,381	(536)	23,845			26
27	Other (specify):* **PUBLIC RELATIONS**			18,056	18,056		18,056	(18,056)				27
28	**TOTAL General Administration**	161,208	22,296	651,569	835,073	(12,581)	822,492	(22,883)	799,609			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,752,347	502,847	909,145	3,164,339	(16,853)	3,147,486	(69,635)	3,077,851			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WINNING WHEELS #0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			142,527	142,527	(8,544)	133,983	29,122	163,105			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,115	19,115		19,115	(49,121)	(30,006)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			161,642	161,642	(8,544)	153,098	(19,999)	133,099			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					25,397	25,397		25,397			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,920	43,920		43,920		43,920			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			43,920	43,920	25,397	69,317		69,317			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,752,347	502,847	1,114,707	3,369,901		3,369,901	(89,634)	3,280,267			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,840)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,365)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(286)	21		7
8	Laundry for Non-Patients	(21,000)	4		8
9	Non-Straightline Depreciation	24,771	30		9
10	Interest and Other Investment Income	(49,676)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,056)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	(18,547)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,423)	21&24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,422)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	762	30	33
34	Adjustments for Related Organization Costs (Schedule VII)	3,026		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 3,788		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (89,634)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 25,397	38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 25,397		47

WINNING WHEELS

ID# 0024745

Report Period Beginning: 07/01/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,840)	0	0	0	0	0	0	0	0	0	0	(1,840)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(21,000)	0	0	0	0	0	0	0	0	0	0	(21,000)	4
5	Heat and Other Utilities	(5,365)	0	0	0	0	0	0	0	0	0	0	(5,365)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(28,205)	0	0	0	0	0	0	0	0	0	0	(28,205)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	(18,547)	0	0	0	0	0	0	0	0	0	0	(18,547)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(18,547)	0	0	0	0	0	0	0	0	0	0	(18,547)	16
	C. General Administration													
17	Administrative	0	0	50,951	70,490	(153,500)	0	0	0	0	0	0	(32,059)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	1,462	0	0	0	0	0	0	0	0	1,462	19
20	Fees, Subscriptions & Promotions	0	0	417	0	0	0	0	0	0	0	0	417	20
21	Clerical & General Office Expenses	(286)	(1,522)	2,982	0	0	0	0	0	0	0	0	1,174	21
22	Employee Benefits & Payroll Taxes	0	0	23,132	0	769	0	0	0	0	0	0	23,901	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(1,901)	1,628	0	0	0	0	0	0	0	0	(273)	24
25	Other Admin. Staff Transportation	0	0	1,087	0	0	0	0	0	0	0	0	1,087	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	(536)	0	0	0	0	0	0	(536)	26
27	Other (specify):*	(18,056)	0	0	0	0	0	0	0	0	0	0	(18,056)	27
28	**TOTAL General Administration**	(18,342)	(3,423)	81,659	70,490	(153,267)	0	0	0	0	0	0	(22,883)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(65,094)	(3,423)	81,659	70,490	(153,267)	0	0	0	0	0	0	(69,635)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	25,533	0	2,962	627	0	0	0	0	0	0	0	29,122	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(49,676)	0	555	0	0	0	0	0	0	0	0	(49,121)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(24,143)	0	3,517	627	0	0	0	0	0	0	0	(19,999)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(89,237)	(3,423)	85,176	71,117	(153,267)	0	0	0	0	0	0	(89,634)	45

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES, IN	0.00%	BIG MEADOWS,INC.	SAVANNA	LYNDON PROGRESS		DAY TREATMEN
	0.00%	PLEASANT VIEW	MORRISON	CENTER	LYNDON	REHABILITATIC
WINNING WHEELS, INC.	100.00%	STRIVE	PROPHETSTOWN	LYNDON PLAY &		
				LEARN CENTER	LYNDON	CHILD DAY CAR
				FRONTIER HOLLOW		INDEPENDENT
				APARTMENTS	PROPHETSTOWN	LIVING FACILIT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	DAY CARE BENEFITS	$ 15,106	LYNDON PLAY & LEARN	100.00%	$ 15,875	$ 769	1
2	V	26	INSURANCE	536	LYNDON PROGRESS CENTER	100.00%		(536)	2
3	V	17	PROFESSIONAL SERVICES	153,500	AMERICAN HEALTH ENTERPRISES		156,293	2,793	3
4	V				MANAGEMENT COMPANY				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 169,142			$ 172,168	$ * 3,026	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AMERICAN HEALTH ENTERPRISES, INC.								$		1
2	ALAN GAPINSKI	PRESIDENT	DIRECT MANAGEMENT								2
3	(100% OWNER - AHE, INC)										3
4								MANAGEMENT			4
5	WINNING WHEELS, INC			0.00	29,850	18	36.00	FEES	153,500	17,3	5
6	S.T.R.I.V.E.			0.00	7,850	5	10.00	"	93,500	17,3	6
7	BIG MEADOWS, INC.			100.00	22,800	14	28.00	"	121,403	17,3	7
8	PLEASANT VIEW			100.00	17,100	10	20.00	"	58,109	17,3	8
9	OTHERS (NON-COST REPORTING)			0.00	7,477	3	6.00	"	84,000	N/A	9
10											10
11											11
12				TOTAL	85,077		100.00				12
13								TOTAL	$ 510,512		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AMERICAN HEALTH ENTERPRISES, INC.
Street Address: 501 6TH AVE. WEST
City / State / Zip Code: LYNDON, IL 61261
Phone Number: (815-778-3683
Fax Number: (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	DIRECT COST	1	1	$ 50,951	$ 50,951	1	$ 50,951	1
2	17	ADMINISTRATIVE	GROSS REVENUE	9,812,000	5	200,827	200,827	3,444,000	70,490	2
3	19	DATA PROCESSING	GROSS REVENUE	9,812,000	5	4,164	0	3,444,000	1,462	3
4	20	DUES, FEES, SUBSCRIPTIONS	GROSS REVENUE	9,812,000	5	1,189	0	3,444,000	417	4
5	21	SUPPLIES, PHONE	GROSS REVENUE	9,812,000	5	8,497	0	3,444,000	2,982	5
6	24	TRAINING SEMINARS	GROSS REVENUE	9,812,000	5	4,637	0	3,444,000	1,628	6
7	25	ADMIN. TRANSPORTATION	GROSS REVENUE	9,812,000	5	3,096	0	3,444,000	1,087	7
8	19	ACCOUNTING FEES	DIRECT COST	2	2	1,600	0	0	0	8
9	30	DEPR'N. VEHICLES	GROSS REVENUE	9,812,000	5	8,439	0	3,444,000	2,962	9
10	30	DEPR'N. EQUIP.	GROSS REVENUE	9,812,000	5	1,785	0	3,444,000	627	10
11	32	INTEREST (VEHICLES)	GROSS REVENUE	9,812,000	5	1,582	0	3,444,000	555	11
12	32	INTEREST (WORK. CAP.)	DIRECT COST	2	2	4,500	0	0	0	12
13	22	BENEFITS	% OF SALARIES	377,341	5	71,875	0	121,441	23,132	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 363,142	$ 251,778		$ 156,293	25

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FARMERS NATIONAL BANK		X	MORTGAGE	$10,000.00	04/09/97	$ 493,557	$ 204,804	05/05/02	7.35%	$ 19,115	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$10,000.00		$ 493,557	$ 204,804			$ 19,115	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 493,557	$ 204,804			$ 19,115	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior MASONRY Frame CONCRETE BLOCK Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING SITE	504,424	1973	$ 23,500	1
2					2
3	TOTALS	504,424		$ 23,500	3

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1979	1979	$ 1,526,858	$ 26,124	VARIOUS	$ 50,895	$ 24,771	$ 1,060,112	4
5			1979	1979	22,848		5	762	762	18,350	5
6			1979	1979	3,826	58	20	58		3,826	6
7			1985	1979	4,226	211	20	211		3,228	7
8			1987	1979	11,212	561	20	561		7,615	8
	Improvement Type**										
9	SEE DETAIL ATTACHED				456,926	26,143	VARIOUS	26,143		231,832	9
10	CARPET DIETARY AND MAIN			1997	415	83	5	83		297	10
11	COMPRESSOR FOR AIR CONDITIONER			1997	6,500	650	10	650		2,329	11
12	LAYING BRICK			1997	768	38	20	38		138	12
13	GARAGE DOOR			1997	667	33	20	33		120	13
14	GARBAGE DISPOSAL			1997	950	63	15	63		164	14
15	CARPETING			1997	2,255	451	5	451		1,616	15
16	PAINTING			1997	1,948	195	10	195		698	16
17	TILING			1997	18,869	943	20	943		3,381	17
18	LANDSCAPING			1997	1,480	148	10	148		530	18
19	SOFFIT			1997	4,495	225	20	225		599	19
20	BLACKTOP			1997	8,260	551	15	551		1,973	20
21	FAUCETS			1997	738	49	15	49		176	21
22	SOFFIT ADDITION			1998	951	48	20	48		147	22
23	COMPRESSOR FOR AIR CONDITIONER			1998	10,811	1,081	10	1,081		2,793	23
24	DINING ROOM IMP-GLASS			1998	973	49	20	49		134	24
25	FOLDING ROOM WALLS/DOORS			1998	5,099	255	20	255		637	25
26	FLOORING			1998	2,642	264	10	264		682	26
27	ALARM INSTALLATION			1998	952	95	10	95		246	27
28	CABINETS			1998	7,745	387	20	387		904	28
29	AIR CONDITIONERS 3.5 TON			1999	1,257	126	10	126		262	29
30	NATURE TRAIL LANDSCAPING			1999	18,965	1,897	10	1,897		3,161	30
31	PAINTING HALLWAY			1999	1,285	129	10	129		214	31
32	DUMPSTERS PAD AND FENCING			1999	1,874	375	5	375		593	32
33	POLYVINL FENCING 328 FT.			1999	2,375	119	20	119		148	33
34	GAZEBO			1999	8,200	410	20	410		513	34
35	FLOORING			1999	5,553	555	10	555		648	35
36	TOTAL (lines 4 thru 35)				$ 2,141,923	$ 62,316		$ 87,849	$ 25,533	$ 1,348,066	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REMODEL DINING ROOM			1999	6,724	672	10	672		785	9
10	ABOVE GROUND PETROLEUM TANKS			1999	14,566	1,457	10	1,457		1,699	10
11	LANDSCAPING			1999	6,091	870	7	870		1,015	11
12	SECURITY SYSTEM UPGRADE			1999	5,472	782	7	782		847	12
13	GAZEBO INSTALLATION			1999	1,998	100	20	100		108	13
14	FRONT LIGHT FIXTURES			2000	4,507	225	10	225		225	14
15	STORM WATER PUMP			2000	2,404	172	7	172		172	15
16	PARKING LOT			2000	13,819	691	10	691		691	16
17	KITCHEN AND DINING AREA ROOF			2000	41,800	1,625	15	1,625		1,625	17
18	BREAKROOM FLOORING			2000	1,294	92	7	92		92	18
19	BUG BLOWER			2000	1,265	63	10	63		63	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 99,940	$ 6,749		$ 6,749	$	$ 7,322	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 525,280	$ 54,950	$ 54,950	$	VARIOUS	$ 279,977	37
38	Current Year Purchases	27,201	2,207	2,207		VARIOUS	2,207	38
39	Fully Depreciated Assets	324,157		627	627		324,157	39
40	RELATED ORGANIZATION ALLOCATION							40
41	TOTALS	$ 876,638	$ 57,157	$ 57,784	$ 627		$ 606,341	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	PATIENT TRANSPORTATI	VARIOUS	VARIOUS	$ 136,946	$ 10,459	$ 10,459	$		$ 102,448	42
43	SNOW REMOVAL	93 DODGE	1993	20,645	2,065	2,065			15,312	43
44	BUS	95 FORD	1996	37,812	3,781	3,781			18,276	44
45	RELATED ORGANIZATIO					2,962	2,962			45
46	TOTALS			$ 195,403	$ 16,305	$ 19,267	$ 2,962		$ 136,036	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,337,404	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 142,527	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 163,105	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 29,122	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,097,765	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	THERAPY ANNEX	$ 590,321	58
59			59
60			60
61		$ 590,321	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	109	109	951	1,169
3	Classroom Wages (a)	3,896	2,964		6,860
4	Clinical Wages (b)		1,482		1,482
5	In-House Trainer Wages (c)	1,604	1,604	14,033	17,241
6	Transportation				
7	Contractual Payments	229	229	2,004	2,462
8	Nurse Aide Competency Tests	178	178	1,559	1,915
9	TOTALS	$ 6,016	$ 6,566	$ 18,547	$ 31,129
10	SUM OF line 9, col. 1 and 2 (e)	$ 12,582			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 12,716

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	4
2. From other facilities (f)	26
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	9
TOTAL TRAINED	43

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 736,472	$ 757,833	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 68,833)	306,092	464,626	3
4	Supply Inventory (priced at)	29,574	45,594	4
5	Short-Term Investments	1,519,503	2,871,940	5
6	Prepaid Insurance	5,323	8,019	6
7	Other Prepaid Expenses	9,740	28,192	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): SEE ATTACHED	442,010	197,857	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,048,714	$ 4,374,061	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,500	66,784	13
14	Buildings, at Historical Cost	2,219,015	3,112,682	14
15	Leasehold Improvements, at Historical Cos		107,843	15
16	Equipment, at Historical Cost	1,072,041	1,527,312	16
17	Accumulated Depreciation (book methods)	(2,253,111)	(2,782,225)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	590,321	643,951	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,651,766	$ 2,676,347	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,700,480	$ 7,050,408	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 165,588	$ 188,418	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	108,555	108,555	29
30	Accrued Salaries Payable	68,693	100,503	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,433	17,568	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	1,174,548	49,029	36
37	STRIVE REVENUE BONDS		16,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,528,817	$ 480,073	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	96,249	96,249	40
41	Bonds Payable		213,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 96,249	$ 309,249	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,625,066	$ 789,322	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,075,414	$ 6,261,086	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,700,480	$ 7,050,408	48

***(See instructions.)**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,930,465	1
2	Restatements (describe):		2
3	JUNE 1999 NET INCOME	13,833	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,944,298	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	233,323	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) SUBSIDIARY COMPANIES		15
16	Other (describe) NET INCOME	83,465	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 316,788	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,261,086	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,237,966	1
2	Discounts and Allowances for all Levels	(12,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,225,966	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	27,856	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,840	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	286	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	21,000	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 50,982	23
	D. Non-Operating Revenue		
24	Contributions	230,735	24
25	Interest and Other Investment Income***	49,676	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 280,411	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION REVENUE	45,865	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 45,865	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,603,224	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	753,567	31
32	Health Care	1,575,699	32
33	General Administration	835,073	33
	B. Capital Expense		
34	Ownership	161,642	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	43,920	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,369,901	40
41	**Income before Income Taxes (line 30 minus line 40)****	233,323	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 233,323	43

***** **This must agree with page 4, line 45, column 4.**

****** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

******* **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,943	2,135	$ 44,867	$ 21.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,625	13,495	215,649	15.98	3
4	Licensed Practical Nurses	7,857	8,343	112,923	13.54	4
5	Nurse Aides & Orderlies	55,849	58,107	535,080	9.21	5
6	Nurse Aide Trainees	1,081	1,081	8,342	7.72	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,874	1,948	22,149	11.37	9
10	Activity Assistants	4,283	4,387	46,094	10.51	10
11	Social Service Workers	5,432	5,862	73,834	12.60	11
12	Dietician					12
13	Food Service Supervisor	2,048	2,080	29,729	14.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,189	21,670	135,833	6.27	15
16	Dishwashers					16
17	Maintenance Workers	7,851	8,715	72,592	8.33	17
18	Housekeepers	8,176	8,648	56,044	6.48	18
19	Laundry	8,250	8,924	57,950	6.49	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,370	14,291	161,208	11.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,959	2,095	18,661	8.91	31
32	Other Health Care(specify)	12,813	14,392	161,392	11.21	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,600	176,173	$ 1,752,347 *	$ 9.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	22	$ 890	1/3	35
36	Medical Director	236	23,625	9/3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	60	2,400	10/3	39
40	Physical Therapy Consultant	542	27,115	10a/3	40
41	Occupational Therapy Consultant	155	6,987	10a/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	945	37,780	10a/3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Recreational Therapy	48	1,920	11/3	47
48	Psychological Consultant	18	1,770	10a/3	48
49	TOTAL (lines 35 - 48)	2,026	$ 102,487		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
American Health Enterprises	$ 153,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 153,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Lindgren,Callihan		$
Van Osdol & Co. LTD	Audit	9,077
Olive LLP	Financial Consultant	900
Ward Murray Pace		
And Johnson	Legal	924
Duane Morris&Heckscher	Legal	192
Achieve	Software Maintenance	1,262
Creative Solutions	Medical Records	2,087
Unisoft Systems	Dietary Support	1,667
Essex	Internet Service	240
Computer Intergration	Webb Site Hosting	684
Midwest Auto Time	Time System Maintenance	1,496
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 18,529

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,126
Unemployment Compensation Insurance	100
FICA Taxes	131,702
Employee Health Insurance	36,920
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	4,102
RETIREMENT	11,025
LT &ST DISABILITY INSURANCE	14,795
PHYSICALS	1,291
CHILD CARE	18,126
RELATED PARTY ALLOCATION	23,901
EMPLOYEE CHRISTMAS PARTY,GIFTS,OTHI	23,743
TOTAL (agree to Schedule V, line 22, col.8)	$ 321,831

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	17,324
Health Care Worker Background Check	
(Indicate # of checks performed 58)	580
I.H.C.A.	3,009
OTHER DUES,FEES,BOOKS	437
SUBCRIPTIONS & DUES	4,646
CARF RENEWAL APPLICATION	2,400
RELATED PARTY ALLOCATION	417
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,813

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,901
In-State Travel	20,544
LISTING ATTACHED	
RELATED PARTY ALLOCATION	1,628
Seminar Expense	
LESS:OUT OF STATE	(1,901)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,172

**See instructions.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HEALTH CARE ASSOC.$3009**

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,092** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **43,920**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **1,840**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **45,865**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **LINDGREN,CALLIHAN,VANOSDOLCPA LTD** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.